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Research Article

Assessing Mental Health Awareness and Stigma in Hartford, Connecticut, USA

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Abstract: Mental health stigma remains a major barrier to timely help-seeking, disclosure, and community support. This study assessed mental health awareness and stigma among adults in Hartford, Connecticut, using a descriptive cross-sectional survey and key informant interviews. A structured questionnaire was completed by 170 adults, and 10 community informants participated in semi-structured interviews. Descriptive findings showed moderate mental health awareness, with particularly strong recognition of the importance of early intervention but weaker awareness of available support services. Education level was significantly associated with awareness. Item-level stigma findings suggested relatively low endorsement of overtly stigmatizing beliefs, although discomfort, concealment-related attitudes, and fear of social judgment persisted. The reported correlation analysis showed an inverse association between awareness and stigma ($r = -0.62$, $p < 0.001$). Qualitative themes highlighted limited service access, fear of being judged, demand for more community education, and inconsistent informal support. Overall, the findings support community-based mental health education, improved service visibility, and locally trusted anti-stigma messaging. Interpretation should remain cautious because the study used non-probability sampling, self-reported measures, and a cross-sectional design.

Keywords: mental health, awareness, stigma, community-based study, Hartford, Connecticut, public health

1. Introduction

Mental health is a major public health concern in the United States and globally. Public understanding of common mental health conditions, recognition of early warning signs, and knowledge of where to seek help can shape whether people receive support early or delay care until distress becomes more severe. Even where awareness has improved, stigma continues to obstruct disclosure, help-seeking, and supportive social responses [1,4,6].

In this study, mental health awareness refers to practical public knowledge about mental health conditions, their symptoms, contributing factors, and available support services. Mental health stigma refers to negative beliefs, social distancing, stereotyping, concealment pressures, and discriminatory attitudes directed toward people living with mental illness [3,5]. These processes matter at community level because awareness and stigma influence how residents talk about distress, whether families encourage help-seeking, and how comfortable people feel accessing formal services [4,6,11].

Urban communities can show wide variation in mental health knowledge and attitudes because education, neighborhood conditions, service visibility, prior contact with mental illness, and broader social narratives do not operate evenly across groups [6,7,11]. Hartford, Connecticut, offers a relevant setting for examining these issues because community responses to mental health are likely shaped not only by knowledge, but also by trust, service accessibility, and social judgment.

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The present study therefore aimed to assess mental health awareness and stigma among adults in selected Hartford neighborhoods, identify demographic patterns, and explore community explanations for persistent barriers. The practical purpose was to generate evidence that can inform local mental health education, service outreach, and anti-stigma interventions.

2. Literature Review

2.1 Conceptual background

Public awareness of mental health is not limited to knowing diagnostic labels. It includes recognizing symptoms, understanding that mental illness is common and treatable, and knowing that professional and community support are available. Reviews of mental health literacy instruments have shown that awareness is multidimensional and that measurement quality varies substantially across studies, which makes clear definition and careful scale construction important [2].

Stigma is similarly multidimensional. It includes public stigma, self-stigma, anticipated judgment, social distancing, and institutional barriers. Foundational work on mental illness stigma has shown that stigma involves labeling, stereotyping, separation, status loss, and discrimination operating within a context of power [5]. Later work has emphasized that stigma measurement is complex because attitudes, emotions, and intended behaviors do not always move together [3].

A large body of evidence shows that stigma affects help-seeking. Systematic reviews have found that perceived stigma, self-stigma, embarrassment, and anticipated negative judgment are recurring barriers to seeking care [4,12]. Public stigma in the United States remains widespread, although its expression varies by condition, population, and social context [6].

Community context also matters. Neighborhood-level work has shown that stigma is influenced not only by individual characteristics but also by broader social environment [7]. This means that anti-stigma efforts should not be framed solely as individual education problems. They also require visible services, trusted messengers, and repeated public normalization of mental health discussions.

2.2 Empirical studies

Educational exposure has repeatedly been linked with better mental health understanding and lower stigma. In a study of college students, Shim et al. found that structured mental health education improved awareness and reduced stigma-related attitudes across the course period [1]. In younger populations, Bulanda et al. also reported that youth-led anti-stigma activity could improve mental health attitudes [8].

Research in applied settings points in the same direction. Dalky et al. reported that mental health knowledge, attitudes, and intended behaviors were interrelated among healthcare providers, and that knowledge gaps coexisted with residual stigma [9]. Vidourek and Burbage likewise found that stigma remained a major perceived barrier to help-seeking among students, even when participants expressed sympathy toward people with mental illness [10].

Recent evidence also suggests that broader health literacy shapes mental health attitudes. Fleary et al. found that higher functional and communicative health literacy were associated with lower mental health stigma and lower aversion to mental health help-seeking among adults [11]. Taken together, the literature suggests that awareness, literacy, and stigma are closely linked, but that community-level barriers such as judgment, silence, and limited service visibility still require local study.

3. Methodology

This study used a descriptive cross-sectional design to examine mental health awareness and stigma among adults living in selected urban neighborhoods in Hartford, Connecticut. The target population comprised adults aged 18 years and older residing in the selected communities.

The sample size was estimated with the Yamane formula for finite populations: n = N / (1 + Ne2). Using an estimated adult population of 10,000 and a margin of error of 0.08, the calculation yielded approximately 154 participants. After allowing 10% for non-response or incomplete questionnaires, the final target sample was set at 170.

Participants were recruited through purposive and convenience sampling to obtain variation in age, gender, education, and employment. Eligibility criteria required residence in the selected Hartford neighborhoods, age 18 years or older, and provision of informed consent.

Primary data were collected with a structured questionnaire and semi-structured interviews. The questionnaire assessed awareness of common mental health conditions, attitudes toward people with mental illness, and perceived stigma using five-point Likert items. For stigma analyses, positively worded supportive items were reverse-coded when the composite stigma score was generated. Key informant interviews were conducted with 10 community leaders, program staff, and volunteers to explore local perceptions, barriers to help-seeking, and available support structures.

Quantitative data were analyzed in SPSS using frequencies, percentages, means, standard deviations, cross-tabulations, chi-square tests, and Pearson correlation. Qualitative data were analyzed thematically to identify recurrent barriers, community assets, and recommendations. Participation was voluntary, confidentiality was maintained, and data collection took place in community settings intended to support participant comfort and privacy.

4. Results

Table 1. Demographic characteristics of respondents (n = 170)

Variable	Category	Frequency	Percentage (%)
Gender	Male	80	47.1
	Female	90	52.9
Age group	18-25	40	23.5
	26-35	50	29.4
	36-45	40	23.5
	46-60	30	17.6
	60+	10	5.9
Education level	Primary	25	14.7
	Secondary	60	35.3
	Tertiary	70	41.2

	Postgraduate	15	8.8
Employment status	Student	35	20.6
	Employed	70	41.2
	Self-employed	40	23.5
	Unemployed	20	11.8
	Other	5	2.9

The sample was balanced by gender and included adults across all age groups. Most respondents had at least secondary education, and the employment profile suggested a socially mixed urban sample. This distribution supports the descriptive aim of capturing a range of community perspectives rather than a narrowly defined subgroup.

Table 2. Descriptive statistics for mental health awareness

Awareness item	Mean	SD	% Agree/Strongly Agree
Understands the meaning of mental health	4.10	0.80	78
Can identify common mental health conditions	3.90	0.90	72
Is aware of mental health support services	3.50	1.00	60
Believes mental health problems can affect anyone	4.30	0.70	82
Believes early intervention improves outcomes	4.20	0.80	80
Feels confident talking about mental health	3.80	0.90	68

Awareness was generally moderate to high, with strongest agreement around the universality of mental health problems and the value of early intervention. The comparatively lower score for awareness of support services suggests that general knowledge may exceed knowledge of where to obtain help locally. The awareness scale mean reported in the manuscript was 3.97 (SD 0.68), with Cronbach alpha of 0.81.

Table 3. Descriptive statistics for stigma-related items

Item	Mean	SD	% Agree/Strongly Agree

People with mental illness are dangerous	2.80	1.00	30
I would feel uncomfortable working with someone with mental illness	2.50	0.90	25
Mental illness is a sign of weakness	2.30	0.80	20
People should hide mental illness	2.70	0.90	28
I would encourage a family member to seek help	4.00	0.80	75
Society should do more to support mental health	4.10	0.70	78

Item-level findings suggest relatively low endorsement of overtly stigmatizing beliefs, but they also show that discomfort and concealment-related attitudes persist. Supportive items were reverse-coded when the stigma composite was generated for inferential analyses. The manuscript reported a stigma composite mean of 3.06 (SD 0.72) and Cronbach alpha of 0.76.

Table 4. Cross-tabulation of education level and awareness category

Education level	Low awareness	High awareness	Total	% High awareness
Primary	20	5	25	20
Secondary	25	35	60	58
Tertiary	20	50	70	71
Postgraduate	2	13	15	87

Awareness increased across education groups. Respondents with tertiary and postgraduate education were much more likely to fall into the high-awareness category than those with primary education. Based on the displayed frequencies, the corrected chi-square value is 25.09 with 3 degrees of freedom ($p < 0.001$), indicating a statistically significant association.

Table 5. Cross-tabulation of age group and stigma category

Age group	Low stigma	High stigma	Total	% Low stigma
18-25	25	15	40	62.5
26-35	35	15	50	70.0

36-45	30	10	40	75.0
46-60	20	10	30	66.7
60+	5	5	10	50.0

The proportions suggest some variation by age, but the pattern is modest and does not support a statistically significant age-stigma association. Based on the displayed counts, the corrected chi-square value is 3.03 with 4 degrees of freedom ($p = 0.55$). This indicates that stigma was not meaningfully differentiated by age group in this sample.

Table 6. Reported correlation between awareness and stigma composite

Variables	Awareness	Stigma
Awareness	1.00	-0.62
Stigma	-0.62	1.00

The reported Pearson correlation was negative and moderately strong ($r = -0.62$, $p < 0.001$). This suggests that greater awareness tended to coincide with lower stigma scores. Because the design was cross-sectional, this finding should be interpreted as an association rather than evidence of causality.

Table 7. Themes from key informant interviews (n = 10)

Theme	Description	Frequency
Lack of mental health services	Participants described limited access to nearby and affordable mental health services.	7
Fear of being judged	Stigma and anticipated social judgment discouraged help-seeking.	6
Need for more awareness campaigns	Schools, churches, and local media were identified as important education channels.	8
Family and religious support	Informal support existed, but it was inconsistent and not always sufficient.	5

The qualitative data add practical depth to the survey findings. Respondents did not describe stigma as a purely attitudinal problem. They linked it to service access, anticipated judgment, and the uneven reliability of informal support networks. The repeated mention of schools, churches, and media also suggests that anti-stigma work may be more effective when delivered through trusted local institutions.

5. Discussion

This study found that adults in selected Hartford neighborhoods had a moderate level of mental health awareness, but awareness was unevenly distributed across education levels. Respondents generally rejected strongly derogatory beliefs about mental illness, yet discomfort and concealment-oriented responses remained visible. In other words, explicit stigma appeared lower than older stereotypes would predict, but subtler forms of stigma were still present.

The education gradient in awareness is consistent with prior work showing that structured educational exposure can improve mental health understanding and reduce stigma-related attitudes [1,8]. The inverse awareness-stigma association reported here also fits broader evidence that knowledge and literacy are linked to more favorable mental health beliefs and lower aversion to help-seeking [4,11]. These findings support the argument that awareness campaigns should do more than provide general information. They should also normalize discussion, challenge social distancing, and increase confidence in using services.

The qualitative findings are especially important because they clarify why knowledge alone may not eliminate stigma. Fear of being judged and uncertainty about where to find help mirror barriers identified in systematic reviews of mental health help-seeking [4,12]. This means that community interventions should pair education with visible referral pathways, local service mapping, and messages delivered by trusted community actors.

The study also has limitations. The sample was recruited through purposive and convenience methods, so it should not be treated as representative of all Hartford residents. The design was cross-sectional, which limits causal interpretation. Responses were self-reported and may have been influenced by social desirability. In addition, the manuscript provided summarized quantitative outputs rather than item-level data, so the corrected interpretation presented here focuses on internal consistency and cautious reporting rather than reanalysis of the full dataset.

6. Conclusion and Recommendations

The study suggests that mental health awareness in this Hartford sample was moderate, while overt stigma was relatively low but not absent. Education was strongly linked with awareness, and awareness was inversely associated with stigma. Qualitative findings showed that stigma remains embedded in fear of judgment, uncertainty about service access, and inconsistent community support.

For practice, three recommendations follow. First, community mental health education should focus on service awareness as well as symptom recognition. Second, anti-stigma efforts should be delivered through trusted local settings such as schools, faith communities, and community organizations. Third, access to affordable and visible mental health services should be strengthened so that increased awareness can translate into real help-seeking opportunities.

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